		FOR OHF USE			

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

I. IDPH Facility ID Number: 0036749

Facility Name: Aviston Terrace

Address: 349 West First Street (Number) Aviston (City) 62216 (Zip Code)

County: Clinton

Telephone Number: (618) 228-7040 Fax # (618) 228-7002

IDPA ID Number: 371238076002

Date of Initial License for Current Owners: 01/01/91

Type of Ownership:

[x] VOLUNTARY,NON-PROFIT
- [x] Charitable Corp.
- [ ] Trust

IRS Exemption Code 501 (c)(3)

[ ] PROPRIETARY
- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [ ] "Sub-S" Corp.
- [ ] Limited Liability Co.
- [ ] Trust
- [ ] Other

[ ] GOVERNMENTAL
- [ ] State
- [ ] County
- [ ] Other

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2000 to 06/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANTS' COMPILATION REPORT	(Date)
	(Print Name and Title)	
	(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606	
	(Telephone) (312) 634-3400	Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,500			5,500	13
14	TOTALS	5,500			5,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.18%

D. How many bed-hold days during this year were paid by Public Aid?
86 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 01/01/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	16,472	1,536	1,516	19,524		19,524		19,524			1
2	Food Purchase		23,465		23,465		23,465	(2,581)	20,884			2
3	Housekeeping		2,115		2,115		2,115		2,115			3
4	Laundry		594		594		594		594			4
5	Heat and Other Utilities			8,965	8,965		8,965	64	9,029			5
6	Maintenance	5,390		5,747	11,137		11,137	1,019	12,156			6
7	Other (specify):*											7
8	**TOTAL General Services**	21,862	27,710	16,228	65,800		65,800	(1,498)	64,302			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	114,348	1,608	3,043	118,999		118,999		118,999			10
10a	Therapy			1,063	1,063		1,063		1,063			10a
11	Activities		2,109	111	2,220		2,220	1,702	3,922			11
12	Social Services			2,330	2,330		2,330		2,330			12
13	Nurse Aide Training											13
14	Program Transportation			1,210	1,210		1,210		1,210			14
15	Other (specify):* Routine Dental			1,701	1,701		1,701		1,701			15
16	**TOTAL Health Care and Programs**	114,348	3,717	10,658	128,723		128,723	1,702	130,425			16
	C. General Administration											
17	Administrative	38,982		2,060	41,042		41,042	(2,060)	38,982			17
18	Directors Fees							4,706	4,706			18
19	Professional Services			4,207	4,207		4,207	6,803	11,010			19
20	Dues, Fees, Subscriptions & Promotions			1,529	1,529		1,529	1,234	2,763			20
21	Clerical & General Office Expenses	14,138	2,993	4,046	21,177		21,177	9,404	30,581			21
22	Employee Benefits & Payroll Taxes			16,801	16,801		16,801	24,456	41,257			22
23	Inservice Training & Education			106	106		106	299	405			23
24	Travel and Seminar			754	754		754	1,617	2,371			24
25	Other Admin. Staff Transportation			1,143	1,143		1,143	178	1,321			25
26	Insurance-Prop.Liab.Malpractice							4,512	4,512			26
27	Other (specify):*											27
28	**TOTAL General Administration**	53,120	2,993	30,646	86,759		86,759	51,149	137,908			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	189,330	34,420	57,532	281,282		281,282	51,353	332,635			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aviston Terrace #0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			16,431	16,431		16,431	569	17,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,426	52,426		52,426	5,179	57,605			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							1,771	1,771			34
35	Rent-Equipment & Vehicles			6,000	6,000		6,000	807	6,807			35
36	Other (specify):*											36
37	**TOTAL Ownership**			74,857	74,857		74,857	8,326	83,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,705	2,705		2,705	381	3,086			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,728	33,728		33,728		33,728			42
43	Other (specify):* Nonallowable costs			140,951	140,951		140,951	(140,951)				43
44	**TOTAL Special Cost Centers**			177,384	177,384		177,384	(140,570)	36,814			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	189,330	34,420	309,773	533,523		533,523	(80,891)	452,632			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(141,297)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(422)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,669)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,440	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See schedule 5A	(2,821)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (144,769)		$	30

OHF USE ONLY

48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	63,878		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 63,878		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (80,891)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Aviston Terrace
Provider #0036749 **Schedule 5A**
June 30, 2001

VI. Adjustment Detail
Line 29 - Other (Specify)

	Amount	Reference
Out of state travel	(672)	43
Out of period professional fees	(2,089)	19
Miscellaneous income offset	(60)	21
TOTAL - Line 29	(2,821)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Aviston Terrace

ID# 0036749

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	64	0	0	0	0	0	0	64	5
6	Maintenance	0	36	0	0	983	0	0	0	0	0	0	1,019	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	36	0	0	1,047	0	0	0	0	0	0	1,083	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	1,702	0	0	0	0	0	0	1,702	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	1,702	0	0	0	0	0	0	1,702	16
	C. General Administration													
17	Administrative	0	1,923	0	57,000	(60,983)	0	0	0	0	0	0	(2,060)	17
18	Directors Fees	0	800	0	3,906	0	0	0	0	0	0	0	4,706	18
19	Professional Services	0	1,964	0	0	6,928	0	0	0	0	0	0	8,892	19
20	Fees, Subscriptions & Promotions	0	42	0	1,150	42	0	0	0	0	0	0	1,234	20
21	Clerical & General Office Expenses	0	5,184	0	564	3,716	0	0	0	0	0	0	9,464	21
22	Employee Benefits & Payroll Taxes	0	14,266	0	5,459	2,150	0	0	0	0	0	0	21,875	22
23	Inservice Training & Education	0	0	0	0	299	0	0	0	0	0	0	299	23
24	Travel and Seminar	0	392	0	257	968	0	0	0	0	0	0	1,617	24
25	Other Admin. Staff Transportation	0	30	0	42	106	0	0	0	0	0	0	178	25
26	Insurance-Prop.Liab.Malpractice	0	47	0	4,341	124	0	0	0	0	0	0	4,512	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	24,648	0	72,719	(46,650)	0	0	0	0	0	0	50,717	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	24,684	0	72,719	(43,901)	0	0	0	0	0	0	53,502	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	311	0	0	258	0	0	0	0	0	0	569	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,669)	369	0	3,829	2,650	0	0	0	0	0	0	5,179	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	1,771	0	0	0	0	0	0	1,771	34
35	Rent-Equipment & Vehicles	0	0	0	0	807	0	0	0	0	0	0	807	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,669)	680	0	3,829	5,486	0	0	0	0	0	0	8,326	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	381	0	0	0	0	0	0	0	0	381	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(140,279)	0	0	0	0	0	0	0	0	0	0	(140,279)	43
44	TOTAL Special Cost Centers	(140,279)	0	381	0	0	0	0	0	0	0	0	(139,898)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(141,948)	25,364	381	76,548	(38,415)	0	0	0	0	0	0	(78,070)	45

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc.	100.00	See attached Related Party Schedule		See attached Related Party Schedule		N/A
See Attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 36	$ 36	1
2	V	11	Activity programming		Center for Residential Management, Inc.	**			2
3	V	17	Management fees	6,247	Center for Residential Management, Inc.	**	8,170	1,923	3
4	V	18	Board fees		Center for Residential Management, Inc.	**	800	800	4
5	V	19	Professional fees		Center for Residential Management, Inc.	**	1,964	1,964	5
6	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	42	42	6
7	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	5,184	5,184	7
8	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	14,266	14,266	8
9	V	24	Travel & seminar		Center for Residential Management, Inc.	**	392	392	9
10	V	25	Vehicle expense		Center for Residential Management, Inc.	**	30	30	10
11	V	26	Vehicle, fire & liab. insurance		Center for Residential Management, Inc.	**	47	47	11
12	V	30	Depreciation		Center for Residential Management, Inc.	**	311	311	12
13	V	32	Interest expense		Center for Residential Management, Inc.	**	369	369	13
14	Total			$ 6,247			$ 31,611	$ * 25,364	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary service centers	$	Center for Residential Management, Inc.	**	$ 381	$ 381	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V				**Center for Residential Management, Inc. is				22
23	V				Progressive Housing, Inc.'s parent company.				23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 381	$ * 381	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Progressive Housing, Inc.	100.00%	$ 57,000	$ 57,000	15
16	V	18	Board fees		Progressive Housing, Inc.	100.00%	3,906	3,906	16
17	V	20	Licenses, dues & subscriptions		Progressive Housing, Inc.	100.00%	1,150	1,150	17
18	V	21	Office supplies & telephone		Progressive Housing, Inc.	100.00%	564	564	18
19	V	22	Emp. benefits & payroll taxes		Progressive Housing, Inc.	100.00%	5,459	5,459	19
20	V	24	Travel & seminar		Progressive Housing, Inc.	100.00%	257	257	20
21	V	25	Vehicle expense		Progressive Housing, Inc.	100.00%	42	42	21
22	V	26	Vehicle, fire & liab. insurance		Progressive Housing, Inc.	100.00%	4,341	4,341	22
23	V	32	Interest expense		Progressive Housing, Inc.	100.00%	3,829	3,829	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 76,548	$ * 76,548	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 64	$ 64	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	983	983	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	1,702	1,702	17
18	V	17	Management fees	60,983	Developmental Services of Illinois, Inc.	**		(60,983)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	6,928	6,928	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	42	42	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	3,716	3,716	21
22	V	22	Emp. benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,150	2,150	22
23	V	23	Inservice education		Developmental Services of Illinois, Inc.	**	299	299	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	968	968	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	106	106	25
26	V	26	Vehicle, fire & liab. insurance		Developmental Services of Illinois, Inc.	**	124	124	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	258	258	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	2,650	2,650	28
29	V	34	Rent expense		Developmental Services of Illinois, Inc.	**	1,771	1,771	29
30	V	35	Equipment rental		Developmental Services of Illinois, Inc.	**	807	807	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V				**Developmental Services of Illinois, Inc. is				35
36	V				Progressive Housing, Inc.'s management company.				36
37	V								37
38	V								38
39	Total			$ 60,983			$ 22,568	$ * (38,415)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Cora Flota	Director	Board Member	None	3,530	2 hrs/mtg		Directors Fees	$ 470	L18, C8	1
2	Darrell Boehne	President	Board Member	None	13,982	2 hrs/mtg		Directors Fees	818	L18, C8	2
3	Edward Childers	Vice President	Board Member	None	13,893	2 hrs/mtg		Directors Fees	707	L18, C8	3
4	Kay Schuman Johnson	Treasurer	Board Member	None	3,530	2 hrs/mtg		Directors Fees	470	L18, C8	4
5	Merla McCloud	Recorder	Administrative	None	17,722	2 hrs/mtg		Directors Fees	678	L18, C8	5
6	Orland Bauer	Board Member	Board Member	None	8,119	2 hrs/mtg		Directors Fees	681	L18, C8	6
7	Ron Schroeder	Secretary	Board Member	None	14,122	2 hrs/mtg		Directors Fees	678	L18, C8	7
8	Eugene Humphrey	Board Member	Board Member	None	4,732	2 hrs/mtg		Directors Fees	68	L18, C8	8
9	Duane Satterwhite	Board Member	Board Member	None	4,777	2 hrs/mtg		Directors Fees	23	L18, C8	9
10	Bob Bauer	Board Member	Board Member	None	14,687	2 hrs/mtg		Directors Fees	113	L18, C8	10
11											11
12	See Schedule 7A										12
13								TOTAL	$ 4,706		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES x NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	205,860	20	$ 1,284	$	5,840	$ 36	1
2	17	Management fees	Bed days available	205,860	20	288,000		5,840	8,170	2
3	18	Board fees	Bed days available	205,860	20	28,200		5,840	800	3
4	19	Professional fees	Bed days available	205,860	20	69,236		5,840	1,964	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	270		5,840	7	5
6	21	Office supplies & telephone	Bed days available	205,860	20	18,491		5,840	525	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	41,807		5,840	1,186	7
8	24	Travel & seminar	Bed days available	205,860	20	13,361		5,840	380	8
9	25	Vehicle expense	Bed days available	205,860	20	1,044		5,840	30	9
10	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	1,644		5,840	47	10
11	30	Depreciation	Bed days available	205,860	20	10,967		5,840	311	11
12	32	Interest expense	Bed days available	205,860	20	13,013		5,840	369	12
13	39	Ancillary service centers	Bed days available	205,860	20	13,408		5,840	381	13
14										14
15										15
16										16
17	20	Licenses, dues & subscriptions	Direct method						35	17
18	21	Office supplies & telephone	Direct method						4,659	18
19	22	Emp. benefits & payroll taxes	Direct method						13,080	19
20	24	Travel & seminar	Direct method						12	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 500,725	$		$ 31,992	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

Name of Related Organization: Progressive Housing, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	136	13	$ 409,550	$	16	$ 57,000	1
2	18	Board fees	Number of beds	136	13	33,200		16	3,906	2
3	20	Licenses, dues & subscriptions	Number of beds	136	13	9,775		16	1,150	3
4	21	Office supplies & telephone	Number of beds	136	13	4,793		16	564	4
5	22	Emp. benefits & payroll taxes	Number of beds	136	13	(162)		16	(12)	5
6	24	Travel & seminar	Number of beds	136	13	2,263		16	257	6
7	25	Vehicle expense	Number of beds	136	13	356		16	42	7
8	32	Interest expense	Number of beds	136	13	32,547		16	3,829	8
9										9
10										10
11										11
12	22	Emp. benefits & payroll taxes	Direct method						5,471	12
13	26	Vehicle, fire & liab. insurance	Direct method						4,341	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 492,322	$		$ 76,548	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES x NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Driver, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	205,860	20	$ 2,273	$	5,840	$ 64	1
2	6	Repairs & maintenance	Bed days available	205,860	20	34,653		5,840	983	2
3	11	Activity programming	Bed days available	205,860	20	60,000		5,840	1,702	3
4	19	Professional fees	Bed days available	205,860	20	244,200		5,840	6,928	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	1,464		5,840	42	5
6	21	Office supplies & telephone	Bed days available	205,860	20	130,977		5,840	3,716	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	75,816		5,840	2,150	7
8	23	Inservice education	Bed days available	205,860	20	10,547		5,840	299	8
9	24	Travel & seminar	Bed days available	205,860	20	34,127		5,840	968	9
10	25	Vehicle expense	Bed days available	205,860	20	3,724		5,840	106	10
11	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	4,401		5,840	124	11
12	30	Depreciation	Bed days available	205,860	20	9,100		5,840	258	12
13	32	Interest expense	Bed days available	205,860	20	93,395		5,840	2,650	13
14	34	Rent expense	Bed days available	205,860	20	62,438		5,840	1,771	14
15	35	Equipment rental	Bed days available	205,860	20	28,457		5,840	807	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 795,572	$		$ 22,568	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	IL Health Fac. Auth.-Bond		x	Acquisition of facility	None	03/01/93	$ 4,527,000	$ 678,470	08/15/16	Various	$ 58,518	1
2	Lease Obligation-NCS		x	Hardward/Software	$94.00	10/31/98	3,756	1,613	09/30/03	0.1429	268	2
3												3
4												4
5								Amortization of bond expense			3,252	5
	Working Capital											
6	Community Bank of Galesburg		x	Working Capital	None	08/23/01	286,000	27,765	02/23/02	0.1000	3,280	6
7												7
8												8
9	TOTAL Facility Related				$94.00		$ 4,816,756	$ 707,848			$ 65,318	9
	B. Non-Facility Related*											
10								Miscellaneous Interest Expense			1,937	10
11								Non-allowable interest & fin charges			(12,586)	11
12								Offset interest income			(83)	12
13								Allocated from parent & mgmt. Co.			3,019	13
14	TOTAL Non-Facility Related						$	$			$ (7,713)	14
15	TOTALS (line 9+line14)						$ 4,816,756	$ 707,848			$ 57,605	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aviston Terrace COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036749

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.	N/A		$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES ________ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick & Siding Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	26,400	1991	$ 20,000	1
2					2
3	TOTALS	26,400		$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1986	$ 432,500	$ 10,812	40	$ 10,812	$	$ 113,533	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Expand bedroom			1991	1,790	45	40	45		427	9
10	Sprinkler system			1993	603	116	5	116		916	10
11	Sprinkler system			1996	936	62	15	62		279	11
12	Sprinkler system			1998	1,274	85	15	85		212	12
13	Allocated from parent company				5						13
14	Bathroom Toilets			2001	1,349	45	15	45		45	14
15	Bathroom Tiles			2001	2,720	91	15	91		91	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 441,177	$ 11,256		$ 11,256	$	$ 115,503	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 51,812	$ 5,175	$ 5,175	$	5-10 years	$ 39,236	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Parent and management company allocation			569	569			74
75	TOTALS	$ 51,812	$ 5,175	$ 5,744	$ 569		$ 39,236	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 512,989	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,431	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,000	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 569	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 154,739	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocated from management company			1,771			5
6								6
7	TOTAL				$ 1,771 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: ______ *

10. Effective dates of current rental agreement:
Beginning ______
Ending ______

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 807 Description: Allocated from management company - $807
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident care	1992 Ford van	$ 500.00	$ 6,000	17
18					18
19					19
20					20
21	TOTAL		$ 500.00	$ 6,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** <u>This amount plus any amortization of lease expense must agree with page 4, line 34.</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See schedule 16A				1	2,705	381	1	3,086	13
14	TOTAL			$	1	$ 2,705	$ 381	1	$ 3,086	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Aviston Terrace
Provider # 0036749
June 30,2001

Schedule 16A

XIV. Special Services

Line 13 - Other:

Service	Line & Col. Ref.	Units	Cost	Supplies
Part B Medicare Supplies	L39, C8			381
Emergency Dental	L39, C3	1	2,705	
		1	2,705	381

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 878	$ 878	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 1,699)	41,763	41,763	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,256	2,256	6
7	Other Prepaid Expenses	55,594	55,594	7
8	Accounts Receivable (owners or related parties)	844,431	844,431	8
9	Other(specify): Prepaid Deposit	600	600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 945,522	$ 945,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	441,177	441,177	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,812	51,812	16
17	Accumulated Depreciation (book methods)	(154,739)	(154,739)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	48,235	48,235	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 406,485	$ 406,485	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,352,007	$ 1,352,007	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 102,273	$ 102,273	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,545	50,545	29
30	Accrued Salaries Payable	14,269	14,269	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	26,159	26,159	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	62,266	62,266	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 255,512	$ 255,512	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,613	1,613	39
40	Mortgage Payable			40
41	Bonds Payable	655,690	655,690	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 657,303	$ 657,303	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 912,815	$ 912,815	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 439,192	$ 439,192	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,352,007	$ 1,352,007	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Aviston Terrace
Provider # 0036749
June 30,2001

XV. Balance Sheet **Schedule 17A**

Line 36-Other Current Liabilities	**Operating**	**After Consolidating**
Accrued Respro	38,871	38,871
Accrued Expense	(772)	(772)
Accrued Workshop	16,446	16,446
Accrued Bond Payments	6,282	6,282
Resident Credit Balances	1,439	1,439
Total Line 36-Other Current Liabilities	62,266	62,266

See Accountants' Compilation Report

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 346,076	1
2	Restatements (describe):		2
3	Prior Period Audit Adjustment - Allowance for	(1,696)	3
4	Doubtful Accounts		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 344,380	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	189,146	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Parent & mgmt. company allocation	(94,334)	15
16	Other (describe) added back in column 7		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 94,812	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 439,192	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 578,840	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 578,840	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	141,297	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,389	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 143,686	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	83	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 83	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	60	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 60	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 722,669	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	65,800	31
32	Health Care	128,723	32
33	General Administration	86,759	33
	B. Capital Expense		
34	Ownership	74,857	34
	C. Ancillary Expense		
35	Special Cost Centers	143,656	35
36	Provider Participation Fee	33,728	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 533,523	40
41	**Income before Income Taxes (line 30 minus line 40)****	189,146	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 189,146	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
A federal tax return is filed for the combined divisions of Progressive Housing, Inc.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	440	485	9,472	19.53	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	2,092	2,274	16,472	7.24	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	629	632	5,390	8.53	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,904	2,059	31,880	15.48	20
21	Assistant Administrator					21
22	Other Administrative	296	311	7,102	22.84	22
23	Office Manager					23
24	Clerical	633	656	14,138	21.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	13,233	14,296	104,876	7.34	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,227	20,713	$ 189,330 *	$ 9.14	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 1,516	L1,C3	35
36	Medical Director	Monthly	1,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	629	L10,C3	39
40	Physical Therapy Consultant	9	290	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	773	L10A,C3	43
44	Activity Consultant				44
45	Social Service Consultant	35	1,916	L12,C3	45
46	Other(specify) Psychological	Monthly	432	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	80	$ 6,756		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Kay Buscher	Administrator	0%	$	31,880
Parent Company Allocation	See Attached Schedule 21A			7,102
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	38,982

B. Administrative - Other

Description		Amount
Developmental Services of Illinois, Inc.-Management fees	$	(4,187)
Center for Residential Management, Inc.-Management fees		6,247
Management fees eliminated in column 7		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	2,060

C. Professional Services

Vendor/Payee	Type		Amount
Personnel Planners	U/C Consulting	$	205
Altschuler, Melvoin & Glasser LLP	Accounting		2,208
American Express Tax & Business Services	Accounting		333
Mangum, Smietanka & Johnson	Legal		732
Lawrence Manson	Legal		729
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$	4,207

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	5,526
Unemployment Compensation Insurance		1,396
FICA Taxes		14,484
Employee Health Insurance		16,624
Employee Meals		2,581
Illinois Municipal Retirement Fund (IMRF)*		
Other Employee Benefits		646
TOTAL (agree to Schedule V, line 22, col.8)	$	41,257

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #		Amount
		$	
	N/A		
TOTAL		$	

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	
Advertising: Employee Recruitment		243
Health Care Worker Background Check (Indicate # of checks performed 8)		56
Illinois Health Care Association		828
Various Licenses & Fees		1,306
Various Dues & Subscriptions		285
Allocated from parent & mgmt. company		45
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)	$	2,763

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		1,014
Seminar Expense		9
Allocated from parent & mgmt. co.		1,348
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	2,371

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Aviston Terrace
Provider # 0036749
June 30, 2000

Schedule 21C

XIX. Support Schedules
Section C. Professional Services

Total (agrees to Schedule V, line 19, column 3)			4,207
Parent Company Allocation:			
	American Express Tax & Business Services	Accounting	309
	Altschuler, Melvoin & Glasser LLP	Accounting	613
	Mangum,Smietanka & Johnson	Legal	660
	Lawrence Manson	Legal	382
Management Company Allocation:			
	American Express Tax & Business Services	Accounting	702
	Altschuler,Melvoin & Glasser LLP	Accounting	1,473
	ADP	Payroll Processing	2,549
	Health Outcomes	Consulting	115
	Total Adjustment		6,803
Total (agrees to Schedule V, line 19, column 8)			11,010

See Accountants' Compilation Report

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10					N/A								
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $828**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ______ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ______ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **33,728**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **2,581** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **48%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	16,472	1,536	1,516	19,524	0	19,524	0	19,524
2. Food Purchase	0	23,465	0	23,465	0	23,465	-2,581	20,884
3. Housekeeping	0	2,115	0	2,115	0	2,115	0	2,115
4. Laundry	0	594	0	594	0	594	0	594
5. Heat and Other Utilities	0	0	8,965	8,965	0	8,965	64	9,029
6. Maintenance	5,390	0	5,747	11,137	0	11,137	1,019	12,156
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	21,862	27,710	16,228	65,800	0	65,800	-1,498	64,302
9. Medical Director	0	0	1,200	1,200	0	1,200	0	1,200
10. Nursing & Medical Records	114,348	1,608	3,043	118,999	0	118,999	0	118,999
10a. Therapy	0	0	1,063	1,063	0	1,063	0	1,063
11. Activities	0	2,109	111	2,220	0	2,220	1,702	3,922
12. Social Services	0	0	2,330	2,330	0	2,330	0	2,330
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	1,210	1,210	0	1,210	0	1,210
15. Other (specify)*	0	0	1,701	1,701	0	1,701	0	1,701
16. Total Health Care & Programs	114,348	3,717	10,658	128,723	0	128,723	1,702	130,425
17. Administrative	38,982	0	2,060	41,042	0	41,042	-2,060	38,982
18. Directors Fees	0	0	0	0	0	0	4,706	4,706
19. Professional Services	0	0	4,207	4,207	0	4,207	6,803	11,010
20. Fees, Subscriptions & Promotion	0	0	1,529	1,529	0	1,529	1,234	2,763
21. Clerical & General Office	14,138	2,993	4,046	21,177	0	21,177	9,404	30,581
22. Employee Benefits & Payroll	0	0	16,801	16,801	0	16,801	24,456	41,257
23. Inservice Training & Education	0	0	106	106	0	106	299	405
24. Travel and Seminar	0	0	754	754	0	754	1,617	2,371
25. Other Admin. Staff Trans	0	0	1,143	1,143	0	1,143	178	1,321
26. Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	4,512	4,512
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	53,120	2,993	30,646	86,759	0	86,759	51,149	137,908
29. Total General Administrative	189,330	34,420	57,532	281,282	0	281,282	51,353	332,635
30. Depreciation	0	0	16,431	16,431	0	16,431	569	17,000
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	52,426	52,426	0	52,426	5,179	57,605
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,771	1,771
35. Rent - Equipment & Vehicles	0	0	6,000	6,000	0	6,000	807	6,807
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	74,857	74,857	0	74,857	8,326	83,183
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	2,705	2,705	0	2,705	381	3,086
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	33,728	33,728	0	33,728	0	33,728
43. Other (specify):*	0	0	140,951	140,951	0	140,951	-140,951	0
44. Total Special Cost Ce	0	0	177,384	177,384	0	177,384	-140,570	36,814
45. Grand Total	189,330	34,420	309,773	533,523	0	533,523	-80,891	452,632

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	878	878
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	41,763	41,763
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	2,256	2,256
7. Other Prepaid Expenses	55,594	55,594
8. Accounts Receivable-Owner/Related Party	844,431	844,431
9. Other (specify):	600	600
10. Total current assets	945,522	945,522
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,000	20,000
14. Buildings, at Historical Cost	441,177	441,177
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	51,812	51,812
17. Accumulated Depreciation (book methods)	-154,739	-154,739
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	48,235	48,235
24. Total Long-Term Assets	406,485	406,485
25. Total Assets	1,352,007	1,352,007
CURRENT LIABILITIES		
26. Accounts Payable	102,273	102,273
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	50,545	50,545
30. Accrued Salaries Payable	14,269	14,269
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	26,159	26,159
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	55,984	55,984
37. Other Current Liabilities (specify):	6,282	6,282
38. Total Current Liabilities	255,512	255,512
LONG TERM LIABILITES		
39.Long-Term Notes Payable	1,613	1,613
40.Mortgage Payable	0	0
41.Bonds Payable	655,690	655,690
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	657,303	657,303
46.Total Liabilities	912,815	912,815
47.Total Equity	439,192	439,192
48.Total Liabilities and Equity	1,352,007	1,352,007

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	578,926
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	578,926
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	141,297
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	2,389
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	143,686
24. Contributions	0
25. Interest and Other Investments Income	83
Subtotal - Non-Operating Revenue	83
27. Other Revenue (specify):	-26
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-26
30. Total Revenue	722,669
31. General Services	584,584
32. Health Care	1,451,643
33. General Administration	1,455,763
34. Ownership	640,040
35. Special Cost Centers	1,279,487
35. Provider Participation Fee	192,397
37. Other	0
40. Total Expenses	5,603,914
41. Income Before Income Taxes	########
42. Income Taxes	0
43. Net Income or Loss for the Year	########

Page	
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10	Attachment of Real Estate Bill and fill out form
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12	P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19	The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Aviston Terrace** **02:02 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-80,891	equal to	-80,891	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	57,605	equal to	57,605	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	17,000	equal to	17,000	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	1,771	equal to	1,771	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,807	equal to	6,807	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	1,063	equal to	1,063	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	381	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	65,800	equal to	65,800	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	128,723	equal to	128,723	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	86,759	equal to	86,759	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	74,857	equal to	74,857	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	143,656	equal to	143,656	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	33,728	equal to	33,728	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	114,348	equal to	114,348	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	16,472	equal to	16,472	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	5,390	equal to	5,390	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	38,982	equal to	38,982	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,138	equal to	14,138	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	189,330	equal to	189,330	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,516	< or = to	1,516	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,200	< or = to	1,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	629	< or = to	3,043	-2,414	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	111	-111	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,916	< or = to	2,330	-414	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	38,982	equal to	38,982	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	2,060	equal to	2,060	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	4,207	equal to	4,207	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	41,257	equal to	41,257	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	2,763	equal to	2,763	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,371	equal to	2,371	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	33,728	equal to	33,728	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	2,581	< or = to	24,456	-21,875	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	2,581	equal to	2,581	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	63,878	equal to	63,878	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	707,848	equal to	707,848	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	20,000	equal to	20,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	441,177	equal to	441,177	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	51,812	equal to	51,812	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	154,739	equal to	154,739	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	439,192	equal to	439,192	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	189,146	equal to	189,146	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,352,007	equal to	1,352,007	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1